

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

758

State File No. _____

Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Otto Shaefer3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louisea Brandt Shaefer 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased August 25, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 5 _____ hr. _____ min.9. Birthplace Hermann Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name August Shaefer13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)14. Maiden name Margaret Bierlin15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)16. (a) Informant Alma Shaefer(b) Address Hermann, Missouri R.R. #2017. (a) Burial (b) Date thereof 2/2/43
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hermann, Missouri18. (a) Signature of funeral director Albert H. Hoppe, Inc(b) Address 4700 Washington Blvd.19. (a) FEB 1 1943 (b) J. F. Bruck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
(c) City or town Hermann
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Route # 20
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1943 hour 3 minute 30 M.21. I hereby certify that I attended the deceased from
Dec 3 1942 to Jan 30 1943
that I last saw him alive on Jan 30 1943
and that death occurred on the date and hour stated above.Immediate cause of death _____
Carcinoma of the sigmoid colonDue to _____
Due to _____Other conditions _____
(Include pregnancy within 3 months of death)Major findings: Carcinoma Colon
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work _____ (e) Means of injury _____23. Signature John W. [Signature] (M. D. or other) _____
Address 607 N. [Signature] Date signed 2-2-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Wilford G Burnley
.....
Licensed Embalmer No. *4202*.....

P.O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.